From: Screening Activity (Ref MILPERSMAN 1220-140)
To: Commander, Navy Personnel Command (PERS-445D)

Subj: NAVAL DIVING AND SALVAGE

Ref: (a) MILPERSMAN 1220-190
(b) MILPERSMAN 1220-200

Encl: (1) NAVMED 6150/2, Special Duty Medical Abstract

1. (rank or rate, name, SSN), currently attached to (member's present command), was screened for application for assignment to Naval Diving and Salvage Training Center, Panama City, following the procedures specified in references (a) and (b).

2. The member completed the screening as indicated below:
   (a) Interview conducted by: (name, rank, position, command, date). (Interviewer should include any significant findings pertinent to selection/non-selection of member for requested training.)
   (b) Physical Screening Test conducted by: (name, rank, position, command, date)
      (1) Swim Time: XX min, XX sec
      (2) Run Time: XX min, XX sec
      (3) Sit-ups: XX
      Push-ups: XX
      Pull-ups: XX
   (c) Pressure Test conducted by: (name, rank, position, command/facility, date) or waived (state justification). Pressure test (results to be included as application package) contained in enclosure (1).

3. Based on (satisfactory/unsatisfactory) completion of this screening the member (is/is not) recommended for training at Naval Diving and Salvage Training Center, Panama City. (If member is not recommended, state reason/s.)

(Signature)
(Printed Name)

Copy to:
Member's present command

Engineering Duty Diving Officer Screening Checklist

1.	Diving Physical within 2 years of class date and 1 year of application (reference MILPERSMAN 1220-100 exhibit 8) (1220-160)	☐
2.	Diver Physical Screening Test (reference MILPERSMAN 1220-170)	☐
3.	Hyperbaric Test (reference MILPERSMAN 1220-180)	☐
4.	Diving Officer Questionnaire (reference MILPERSMAN 1220-150)	☐
5.	Fax or e-mail SF-88 – Report of Medical Examination, SF-93 – Report of Waivers, Medical History, BUDS/Diver Medical Screening Questionnaire to: NAVY DIVING AND SALVAGE TRAINING CENTER (NAVDIVSALVTRACEN) SOUTH CRAIG ROAD MEDICAL DEPARTMENT BLDG 350 PANAMA CITY, FL 32407 Phone# (850)235-5215 FAX #(850)235-5993	☐
6.	Get e-mail or fax Medical Screening approval from NDSTC Medical Department listed in #5	☐
7.	Contact Detailer (901)874-3085, shannon.terhune@navy.mil	☐

Application Package Format

1.	Request Letter with following information a) Physical Screening Test b) Diving Officer Interview c) Hyperbaric Test	☐ ☐ ☐
2.	Medical Screening a) SF-88 b) SF-93 c) Diver/BUDS/Medical Screening Questionnaire d) Pre-screening approval from NDSTC Medical Department e) Any waivers	☐ ☐ ☐ ☐ ☐

Mail to: Commander Navy Personnel Command PERS (445D)
5720 Integrity Drive
Millington, TN 38055-4450

Copy to: Naval Sea Systems Command
NAVSEA 00C
1333 Isaac Hull Avenue, SE Stop 1072
Washington Navy Yard, DC 20376-1072

REPORT OF MEDICAL EXAMINATION

1. DATE OF EXAMINATION *(YYYYMMDD)*	2. SOCIAL SECURITY NUMBER

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	4. HOME ADDRESS *(Street, Apartment Number, City, State and ZIP Code)*	5. HOME TELEPHONE NUMBER *(Include Area Code)*

6. GRADE	7. DATE OF BIRTH *(YYYYMMDD)*	8. AGE	9. SEX	10.a. RACIAL CATEGORY *(X one or more)*	b. ETHNIC CATEGORY
			☐ Female ☐ Male	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Decline to Respond	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Respond

11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY	b. CIVILIAN	12. AGENCY *(Non-Service Members Only)*	13. ORGANIZATION UNIT AND UIC/CODE

14.a. RATING OR SPECIALTY *(Aviators Only)*	b. TOTAL FLYING TIME	c. LAST SIX MONTHS

15.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION	16. NAME OF EXAMINING LOCATION, AND ADDRESS *(Include ZIP Code)*
☐ Army ☐ Coast Guard ☐ Navy ☐ Marine Corps ☐ Air Force	☐ Active Duty ☐ Reserve ☐ National Guard	☐ Enlistment ☐ Medical Board ☐ Other ☐ Commission ☐ Retirement ☐ Retention ☐ U.S. Service Academy ☐ Separation ☐ ROTC Scholarship Program	

CLINICAL EVALUATION *(Check each item in appropriate column. Enter "NE" if not evaluated.)*

	Normal	Abnorm	NE
17. Head, face, neck, and scalp			
18. Nose			
19. Sinuses			
20. Mouth and throat			
21. Ears - General *(Int. and ext. canals/Auditory acuity under item 71)*			
22. Drums *(Perforation)*			
23. Eyes - General *(Visual acuity and refraction under items 61 - 63)*			
24. Ophthalmoscopic			
25. Pupils *(Equality and reaction)*			
26. Ocular motility *(Associated parallel movements, nystagmus)*			
27. Heart *(Thrust, size, rhythm, sounds)*			
28. Lungs and chest *(Include breasts)*			
29. Vascular system *(Varicosities, etc.)*			
30. Anus and rectum *(Hemorrhoids, Fistulae) (Prostate if indicated)*			
31. Abdomen and viscera *(Include hernia)*			
32. External genitalia *(Genitourinary)*			
33. Upper extremities			
34. Lower extremities *(Except feet)*			
35. Feet *(See Item 35 Continued)*			
36. Spine, other musculoskeletal			
37. Identifying body marks, scars, tattoos			
38. Skin, lymphatics			
39. Neurologic			
40. Psychiatric *(Specify any personality deviation)*			
41. Pelvic *(Females only)*			
42. Endocrine			

44. NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)*

43. DENTAL DEFECTS AND DISEASE *(Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in Item 44.)*

☐ Acceptable
☐ Not Acceptable Class _____

35. FEET *(Continued) (Circle category)*

Normal Arch	Mild	Asymptomatic
Pes Cavus	Moderate	
Pes Planus	Severe	Symptomatic

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

LABORATORY FINDINGS

45. URINALYSIS	a. Albumin b. Sugar	46. URINE HCG	47. H/H	48. BLOOD TYPE

TESTS	RESULTS	HIV SPECIMEN ID LABEL	DRUG TEST SPECIMEN ID LABEL
49. HIV			
50. DRUGS			
51. ALCOHOL			
52. OTHER			
a. PAP SMEAR			
b.			
c.			

MEASUREMENTS AND OTHER FINDINGS

53. HEIGHT	54. WEIGHT lbs.	55. MIN WGT - MAX WGT MAX BF %	56. TEMPERATURE	57. PULSE

58. BLOOD PRESSURE			59. RED/GREEN *(Army Only)*	60. OTHER VISION TEST
a. 1ST	b. 2ND	c. 3RD		
SYS.	SYS.	SYS.		
DIAS.	DIAS.	DIAS.		

61. DISTANT VISION	62. REFRACTION BY AUTOREFRACTION OR MANIFEST	63. NEAR VISION
Right 20/ Corr. to 20/	By S. CX	Right 20/ Corr. to 20/ by
Left 20/ Corr. to 20/	By S. CX	Left 20/ Corr. to 20/ by

64. HETEROPHORIA *(Specify distance)*

ES ° EX ° R.H. L.H. Prism div. Prism Conv CT NPR PD

65. ACCOMMODATION		66. COLOR VISION *(Test used and result)*	67. DEPTH PERCEPTION *(Test used and score)* AFVT	
Right	Left	PIP /14	Uncorrected	Corrected

68. FIELD OF VISION	69. NIGHT VISION *(Test used and score)*	70. INTRAOCULAR TENSION	
		O.D.	O.S.

71a. AUDIOMETER	Unit Serial Number	71b. Unit Serial Number	72a. READING ALOUD TEST
Date Calibrated *(YYYYMMDD)*		Date Calibrated *(YYYYMMDD)*	

HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000		
Right							Right								72b. VALSALVA
Left							Left								

SAT ☐ UNSAT ☐ SAT ☐ UNSAT

73. NOTES *(Continued)* **AND SIGNIFICANT OR INTERVAL HISTORY** *(Use additional sheets if necessary.)*

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

74.a. EXAMINEE/APPLICANT *(check one)*

☐ IS QUALIFIED FOR SERVICE

☐ IS NOT QUALIFIED FOR SERVICE

75. I have been advised of my disqualifying condition.

a. SIGNATURE OF EXAMINEE	b. DATE *(YYYYMMDD)*
✍	

b. PHYSICAL PROFILE

P	U	L	H	E	S	X	PROFILER INITIALS	DATE *(YYYYMMDD)*

76. SIGNIFICANT OR DISQUALIFYING DEFECTS

ITEM NO.	MEDICAL CONDITION/DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE *(YYYYMMDD)*	QUALI-FIED	DIS-QUALI-FIED	EXAMINER INITIALS	WAIVER RECEIVED	
								SERVICE	DATE *(YYYYMMDD)*

77. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers) (Use additional sheets if necessary.)*

78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify) (Use additional sheets if necessary.)*

79. MEPS WORKLOAD *(For MEPS use only)*

WKID	ST	DATE *(YYYYMMDD)*	INITIAL	WKID	ST	DATE *(YYYYMMDD)*	INITIAL

80. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	PHYSICIAN'S SIGNATURE

81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE

82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE

83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	b. SIGNATURE

84.a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY	b. SIGNATURE

85. This examination has been administratively reviewed for completeness and accuracy.

a. SIGNATURE	b. GRADE	c. DATE *(YYYYMMDD)*

86. WAIVER GRANTED *(If yes, date and by whom)*

☐ **YES**

☐ **NO**

87. NUMBER OF ATTACHED SHEETS

REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

Form Approved
OMB No. 0704-0413
Expires Oct 31, 2006

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397 (SSAN).
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ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a $10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE *(YYYYMMDD)*

4.a. HOME ADDRESS *(Street, Apartment No., City, State, and ZIP Code)*	5. EXAMINING LOCATION AND ADDRESS *(Include ZIP Code)*
b. HOME TELEPHONE *(Include Area Code)*	

X ALL APPLICABLE BOXES:

6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION
☐ Army ☐ Coast Guard	☐ Active Duty	☐ Enlistment ☐ Medical Board ☐ Other *(Specify)*
☐ Navy	☐ Reserve	☐ Commission ☐ Retirement
☐ Marine Corps	☐ National Guard	☐ Retention ☐ U.S. Service Academy
☐ Air Force		☐ Separation ☐ ROTC Scholarship Program

7.a. POSITION *(Title, Grade, Component)*

b. USUAL OCCUPATION

8. CURRENT MEDICATIONS *(Prescription and Over-the-counter)*	9. ALLERGIES *(Including insect bites/stings, foods, medicine or other substance)*

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
10.a. Tuberculosis	○	○
b. Lived with someone who had tuberculosis	○	○
c. Coughed up blood	○	○
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	○	○
e. Shortness of breath	○	○
f. Bronchitis	○	○
g. Wheezing or problems with wheezing	○	○
h. Been prescribed or used an inhaler	○	○
i. A chronic cough or cough at night	○	○
j. Sinusitis	○	○
k. Hay fever	○	○
l. Chronic or frequent colds	○	○
11.a. Severe tooth or gum trouble	○	○
b. Thyroid trouble or goiter	○	○
c. Eye disorder or trouble	○	○
d. Ear, nose, or throat trouble	○	○
e. Loss of vision in either eye	○	○
f. Worn contact lenses or glasses	○	○
g. A hearing loss or wear a hearing aid	○	○
h. Surgery to correct vision *(RK, PRK, LASIK, etc.)*	○	○
12.a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)*	○	○
b. Arthritis, rheumatism, or bursitis	○	○
c. Recurrent back pain or any back problem	○	○
d. Numbness or tingling	○	○
e. Loss of finger or toe	○	○

12. *(Continued)*	YES	NO
f. Foot trouble *(e.g., pain, corns, bunions, etc.)*	○	○
g. Impaired use of arms, legs, hands, or feet	○	○
h. Swollen or painful joint(s)	○	○
i. Knee trouble *(e.g., locking, giving out, pain or ligament injury, etc.)*	○	○
j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	○	○
k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	○	○
l. Bone, joint, or other deformity	○	○
m. Plate(s), screw(s), rod(s) or pin(s) in any bone	○	○
n. Broken bone(s) *(cracked or fractured)*	○	○
13.a. Frequent indigestion or heartburn	○	○
b. Stomach, liver, intestinal trouble, or ulcer	○	○
c. Gall bladder trouble or gallstones	○	○
d. Jaundice or hepatitis *(liver disease)*	○	○
e. Rupture/hernia	○	○
f. Rectal disease, hemorrhoids or blood from the rectum	○	○
g. Skin diseases *(e.g. acne, eczema, psoriasis, etc.)*	○	○
h. Frequent or painful urination	○	○
i. High or low blood sugar	○	○
j. Kidney stone or blood in urine	○	○
k. Sugar or protein in urine	○	○
l. Sexually transmitted disease *(syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)*	○	○
14.a. Adverse reaction to serum, food, insect stings or medicine	○	○
b. Recent unexplained gain or loss of weight	○	○
c. Currently in good health *(If no, explain in Item 29 on Page 2.)*	○	○
d. Tumor, growth, cyst, or cancer	○	○

Reset

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
15.a. Dizziness or fainting spells	○	○
b. Frequent or severe headache	○	○
c. A head injury, memory loss or amnesia	○	○
d. Paralysis	○	○
e. Seizures, convulsions, epilepsy or fits	○	○
f. Car, train, sea, or air sickness	○	○
g. A period of unconsciousness or concussion	○	○
h. Meningitis, encephalitis, or other neurological problems	○	○
16.a. Rheumatic fever	○	○
b. Prolonged bleeding *(as after an injury or tooth extraction, etc.)*	○	○
c. Pain or pressure in the chest	○	○
d. Palpitation, pounding heart or abnormal heartbeat	○	○
e. Heart trouble or murmur	○	○
f. High or low blood pressure	○	○
17.a. Nervous trouble of any sort *(anxiety or panic attacks)*	○	○
b. Habitual stammering or stuttering	○	○
c. Loss of memory or amnesia, or neurological symptoms	○	○
d. Frequent trouble sleeping	○	○
e. Received counseling of any type	○	○
f. Depression or excessive worry	○	○
g. Been evaluated or treated for a mental condition	○	○
h. Attempted suicide	○	○
i. Used illegal drugs or abused prescription drugs	○	○
18. FEMALES ONLY. Have you ever had or do you now have:		
a. Treatment for a gynecological (female) disorder	○	○
b. A change of menstrual pattern	○	○
c. Any abnormal PAP smears	○	○
d. First day of last menstrual period *(YYYYMMDD)*		
e. Date of last PAP smear *(YYYYMMDD)*		

	YES	NO
19. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.	○	○
b. Inability to perform certain motions	○	○
c. Inability to stand, sit, kneel, lie down, etc.	○	○
d. Other medical reasons *(If yes, give reasons.)*	○	○
20. Have you ever been treated in an Emergency Room? *(If yes, for what?)*	○	○
21. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*	○	○
22. Have you ever had, or have you been advised to have any operations or surgery? *(If yes, describe and give age at which occurred.)*	○	○
23. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*	○	○
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*	○	○
25. Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)*	○	○
26. Have you ever been discharged from military service for any reason? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)*	○	○
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*	○	○
28. Have you ever been denied life insurance?	○	○

29. EXPLANATION OF "YES" ANSWER(S) *(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)*

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*

DIVER/BUD/S MEDICAL SCREENING QUESTIONNAIRE

NAME/RANK:	SSN:	DOB:
PRESENT COMMAND:	BR OF SERVICE:	DATE:

(CONCEALMENT OF MEDICAL HISTORY WILL BE REPORTED TO HIGHER AUTHORITIES AND MAY RESULT IN PERMANENT DISQUALIFICATION.)

DIVING MEDICAL QUESTIONS	**Yes**	**No**
1. Have you ever been found medically disqualified for a dive physical or any other physical at any time?	☐	☐
2. Since your last physical, or in the last 18 months, have you been sick, injured, consulted a physician, used medication (including over-the-counter), or been hospitalized for any reason?	☐	☐
3. Have you ever experienced any middle or inner ear dysfunction including inability to equalize middle ear pressure, inner or middle ear surgery, ringing, dysequilibrium, hearing deficit?	☐	☐
4. Is or has your uncorrected vision ever been worse than 20/20 in either eye?	☐	☐
5. Do you have any difficulty distinguishing colors or seeing at night?	☐	☐
6. Have you ever had any corneal surgery, or manipulation to correct poor vision?	☐	☐
7. Since age 12, have you had asthma or wheezing at any time?	☐	☐
8. Have you ever had a collapsed lung (pneumothorax), experienced pulmonary barotrauma, had a positive PPD, or taken INH in the past 6 months?	☐	☐
9. Do you have any skin condition worsened by tight clothing, moisture, or sun exposure?	☐	☐
10. Do you have any musculoskeletal condition that limits intense exercise, suffered any type of fracture in the last 3 months, or had any bone/joint surgery in the last 6 months?	☐	☐
11. Have you ever been evaluated for, or treated for, any psychiatric problems (including depression, anxiety, personality disorder, etc.)?	☐	☐
12. Have you ever had legal, professional or personal problems due to alcohol use, or been diagnosed with dependence, or had any level of treatment for abuse?	☐	☐
13. Have you ever had a migraine or other severe headache?	☐	☐
14. Have you ever had seizures, convulsions or sustained a head injury resulting in loss of consciousness, loss of memory, concussion, or skull fracture?	☐	☐
15. Have you ever had brain surgery?	☐	☐
16. Do you have any area of altered sensation or strength in your body?	☐	☐
17. Have you ever suffered Decompression Sickness or Arterial Gas Embolism?	☐	☐
18. Do you suffer from motion sickness or fear of enclosed spaces?	☐	☐

PATIENT SIGNATURE:	DATE:

DIVER/BUD/S MEDICAL SCREENING QUESTIONNAIRE (Cont'd.)
ANY POSITIVE RESPONSES REQUIRE ELABORATION ON THIS PAGE BY A DIVING MEDICAL OFFICER

NAME/RANK:	SSN:	DOB:
PRESENT COMMAND:	BR OF SERVICE:	DATE:

ADDITIONAL DIVING MEDICAL QUESTIONS		
DMO SCREEN (to be filled out by DMO/UMO, HMO or qualified representative)	**Yes**	**No**
1. SF 88, Report of Medical Examination and SF 93, Report of Medical History are complete, correct, for dive/jump duty and within 1 year of application?	☐	☐
2. Is the physical signed/countersigned by a DMO/UMO or HMO?	☐	☐
3. Every page of member's health record has been reviewed?	☐	☐
4. Any disqualifying condition has a completed, approved waiver from BUMED (Med-21)?	☐	☐
5. Any non-disqualifying condition that might affect dive training is thoroughly documented?	☐	☐

DIVING MEDICAL OFFICER COMMENTS

QUESTION#	COMMENT	CD/NCD?	WAIVER?
		☐ Yes ☐ No	☐ Yes ☐ No

DMO SIGNATURE	**DMO STAMP**
DMO PHONE NUMBER	**DMO FAX NUMBER**

RECORD SCREENING (to be filled in by medical department)		
G6PD results	Sickle cell results	Blood Type

IMMUNIZATION MUST BE COMPLETED AND CURRENT PRIOR TO TRANSFER	☐ Tetanus	Date
	☐ Typhoid	Date
	☐ Yellow Fever	Date
	☐ HAV	Date
	☐ Flu	Date

ADDITIONAL DIVING MEDICAL QUESTIONS (Cont'd.)
DMO SCREEN (to be filled out by DMO/UMO, HMO or qualified representative)

PPD given with diving medical examination. ☐ Yes ☐ No Date	PPD Converter ☐ YES ☐ NO
PPD Converters must complete INH Tx prior to transfer to diver training. PPD annual questionnaire required for converters.	

Date of last Dive Physical (SF 88/93):		
Dental, must be Class I or II. Last examination date:		
Pressure Test, date completed:		
NAVMED 6150/2, Special Duty Medical Abstract required w signature from DMO/UMO/HMO stating Physically Qualified Diving Duty.	Completed	
	☐ YES	☐ NO

Visual Acuity: (must correct to 20/20; if not, waiver required)

- **USN Fleet Diver/Basic Diving Officer, USA OOB, EOD**: 20/200 or better. Waiver required if greater
- **Marine Combat Diver**: 20/100 better eye, 20/200 worse eye, or better
- **Diving Medical Officer and SCUBA**: + or – 8 Diopters
- **SEAL Candidate**: 20/40 in best eye, 20/70 in worst eye (Waiverable to 20/70,20/100. Waiver must be completed.)

Hearing Standards: 1000 Hz 30 db If greater, waiver required. 2000 Hz 35 db 3000 Hz 45 db 4000 Hz 55 db		
The following labs are complete on SF 88: Serology, CBC with DIFF, Lipid panel HIV, G6PD, Sickle Cell, and Blood Type?	☐ YES	☐ NO
SEAL, EOD, USA OOB, and Underwater Construction Diver require Fasting Blood Sugar and Routine Urine. (Appropriate /corresponding lab chits are in the medical record.)	☐ YES	☐ NO
The following studies are complete on SF 88: CXR, EKG, Audiogram, PPD, and Falant? (Appropriate/corresponding studies, reports are in the medical record.)	☐ YES	☐ NO

MEDICAL SCREENER NAME, RANK/RATE, AND TITLE	PHONE NUMBER:
	FAX NUMBER:
Command's mailing address	

NOTE: THE DIVER MEDICAL SCREENING QUESTIONNAIRE AND SF 88/93 MUST BE COMPLETLEY FILLED OUT AND FAXED TO **NAVY DIVING AND SALVAGE TRAINING CENTER (NAVDIVSALVTRACEN), MEDICAL DEPARTMENT, PANAMA CITY, FL** PRIOR TO APPLICATION TO NAVY PERSONNEL COMMAND (NAVPERSCOM) (PERS-401D OR PERS-407CK). ANY WAIVERS MUST HAVE WRITTEN APPROVAL BY BUREAU OF MEDICINE AND SURGERY (BUMED) (MED-21) AND A COPY FAXED TO NAVDIVSALTRACEN, MEDICAL DEPARTMENT.

TELEPHONE:
DSN 436-5215 COMM (850) 235-5215

MEDICAL FAX:
DSN 436-5993 COMM (850) 235-5993

STUDENT SUPPORT OFFICE FAX:
DSN 436- 5242 COMM (850) 235-5242

NOTE: FOR **SEAL CANDIDATES** THE MEDICAL SCREENING QUESTIONNAIRE AND SF 88/93 MUST BE COMPLETELY FILLED OUT AND FAXED TO **NAVY SPECIAL WARFARE CENTER, BUD/S MEDICAL DEPARTMENT** PRIOR TO APPLICATION TO NAVPERSCOM (PERS-401D). ANY WAIVERS MUST HAVE WRITTEN APPROVAL BY BUMED (MED-21) AND A COPY FAXED TO BUD/S MEDICAL DEPARTMENT.

TELEPHONE:
DSN 577-0777 COMM (619) 437-0777

MEDICAL FAX:
DSN 577-5248 COMM (619) 437-5248

PLACE ORIGINAL DIVER MEDICAL SCREENING QUESTIONNAIRE, SF 88/93, AND ANY APPROVED WAIVERS IN MEDICAL RECORD.

NAVDIVSALVTRACEN HOME PAGE:
www.cnet.navy.mil/ndstc/

NAVY SPECIAL WARFARE CENTER BUD/S HOME PAGE:
www.sealchallenge.navy.mil

DIVING STANDARDS:
NAVMED P-117, Manual of the Medical Department, chapter 15, article 15-66, and section III

BUMEDNOTE 6120 of 30 Jul 97 (canc frp: Jul 98):
http://www.navymedicine.med.navy.mil/instructions/external/6120-7-30-97.pdf

MEDICAL WAIVER:
NAVMED P-117, article 15-74

BUMED (MED-21) TELEPHONE:
COMM (202) 762-4342

NAVMED-6150/2 (Rev. 4-70)
(Formerly NAVMED 1346)
S/N 0105-LF-358-6021

HEALTH RECORD

SPECIAL DUTY MEDICAL ABSTRACT

SUMMARY OF PHYSICAL EXAMINATIONS FOR SPECIAL DUTY

DATE	PLACE	PURPOSE	RESULT - RECOMMENDATION *(Duplicate Warners)*	BUMED ACTION	SIG. OF M. O.
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

SUSPENSION FROM SPECIAL DUTY

DATE *(From)* *(To)*	NO. OF DAYS	REASON FOR SUSPENSION	SIGNATURE OF MEDICAL OFFICER
1.			
2.			
3.			
4.			
5.			
6.			
7.			

PERIODIC SPECIAL DUTY REQUALIFICATION

DATE	SIG. OF M. O.	DATE	SIG. OF M. O.	DATE	SIG. OF M. O.
1.		7.		13.	
2.		8.		14.	
3.		9.		15.	
4.		10.		16.	
5.		11.		17.	
6.		12.		18.	

NAME *(Last)* *(First)* *(Middle)*	GRADE/RATE	SERVICE/SOC. SEC. NO.	ORGANIZATION	AGE

ALTITUDE TRAINING, AIR COMPRESSION AND OXYGEN TOLERANCE

DATE	STATION	TYPE OF RUN-REACTION	SIG. OF M. O.
1.			
2.			
3.			
4.			
5.			

EXPLOSIVE DECOMPRESSION TRAINING

DATE	STATION	ALTITUDES-REACTION	SIG. OF M. O.
1.			
2.			

SUBMARINE ESCAPE AND DIVING TRAINING

DATE	STATION	TYPE OF RUN-REACTION	SIG. OF M. O.
1.			
2.			
3.			
4.			
5.			

VISUAL AND DISORIENTATION TRAINING

DATE	STATION	TYPE OF TRAINING	SIG. OF M. O.
1.			
2.			
3.			
4.			

CENTRIFUGE AND EJECTION SEAT TRAINING

DATE	STATION	TYPE OF RUN-REACTIONS	SIG. OF M. O.
1.			
2.			

REMARKS: